Community Health Workers: Essential to Improving Health in Massachusetts

Findings from the Massachusetts Community Health Worker Survey

Division of Primary Care and Health Access
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INTRODUCTION

Community health workers are an essential component of the health care delivery system. They provide the critical link between the health care and human service system and their communities. This report will answer the questions: Who are community health workers (CHWs)? What do they do? What are the defining issues of CHWs as a workforce? How can we better understand and support community health workers in order to improve health outcomes in Massachusetts?

The term "community health worker" is used today as an umbrella term to describe members of the health workforce that function under a multitude of various job titles. The Massachusetts Department of Public Health (MDPH) has undertaken this investigation of CHWs in Massachusetts to be better able to develop effective strategies for their support, development, recruitment and retention.

BACKGROUND

Both in the United States and abroad, CHWs have been an essential component of health care systems for many years. Community health workers (CHWs) improve access to and increase utilization of primary health care, reduce costs of care, improve quality of care, and reduce health disparities. They achieve these goals by serving as the bridge between clients in need and needed health care and human services.

In 1965, Massachusetts established one of the first CHW programs under the Economic Opportunity Act of 1964. For over forty years, the Massachusetts Department of Public Health has supported the use of effective outreach through its funding of community-based agencies, as well as in its own public health services.

In recent years, a number of national and state initiatives have been implemented in an effort to better understand the contributions of CHWs to improving health outcomes. Federal officials and several state governments have shown increased interest in the role of CHWs in reducing health disparities, improving access to care and making disease management more cost-effective.

In Massachusetts, a number of efforts have been implemented on various levels to support and promote the thousands of community health workers employed in community-based agencies. In an effort to better understand CHWs and their current and potential impact on health care delivery in Massachusetts, the MDPH convened, in 1995, an internal cross-departmental CHW Task Force. In 1997, the task force developed a set of expectations for MDPH-funded community-based vendors about CHWs, and determined these next steps:

- Survey the CHW workforce in Massachusetts.
- Support the development of a statewide CHW network.
- Develop and implement a clear MDPH CHW Policy.

The findings of the Massachusetts Community Health Worker Survey are presented in this report.

PURPOSE OF THE MASSACHUSETTS COMMUNITY HEALTH WORKER SURVEY

The primary goals of the Massachusetts Community Health Worker Survey were to:

- Determine basic socioeconomic and demographic characteristics of the CHW workforce
- Identify core job roles and functions
- Create a standardized definition of a CHW for MDPH contracts
- Identify unique skills CHWs require
- Identify job settings, wages and funding
- Gather information on training and supervision
- Identify barriers to workforce recruitment and retention

SURVEY METHODOLOGY

The MDPH used two surveys to collect information, one designed for CHWs and another targeting their supervisors, both developed in collaboration with community health workers and their agencies. Both surveys contained questions on demographics, work and work history, supervision, training and networking opportunities. In addition, the surveys contained questions specific to each role.

MAJOR FINDINGS

A Profile Emerges

- CHWs and their supervisors represent more than 20 different ethnicities, and provide services and information to individuals and families representing more than 20 ethnicities – reflective of Massachusetts' growing variety of ethnic populations.
- CHWs work in all areas of the state, with the heaviest concentration in urban areas.
- CHWs deliver a wide range of services in a number of different settings, their generalist skill set making them critical assets for agencies providing services to clients with multiple needs.
- CHWs possess a wide range of skills, and are hired for their communication and relationship-building skills, along with their knowledge of the neighborhoods and communities they serve.
- CHWs and CHW supervisors are predominantly female.

A Formal Definition of a Community Health Worker

Based on the unique combination of skills and diverse roles identified by the survey, the MDPH developed the following standard CHW definition for use in public health practice, policy development and community-based contracts for services. The MDPH uses this definition to distinguish this outreach work force from other professionals working under MDPH contracts and in other settings.

MDPH Definition of a Community Health Worker (CHW)

A community health worker is a health professional who applies his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out at least one of the following roles:

- Bridging/culturally mediating among individuals, communities and health and human services, including actively building individual and community capacity
- Providing culturally appropriate health education and information
- Assuring that people get the services they need
- Providing direct services, including informal counseling and social support
- Advocating for individual and community needs

A CHW is distinguished from other health professionals because he or she:
- is hired primarily for his or her understanding of the populations he or she serves, and
- conducts outreach at least 50% of the time in one or more of the categories above.

Workforce Issues and Barriers to Recruitment and Retention

- CHW turnover is high.
- CHW wages are low.
- CHW job security is impacted by unpredictable funding.
- There is no formal career ladder for community health workers.
- CHWs are eager to receive additional training.
- Supervisors with experience as a CHW tend to provide higher quality supervision.

SUMMARY OF FINDINGS

Poverty, limited English skills, lack of health insurance, unemployment, immigration and refugee status, homelessness, and an inability to access transportation are among the main barriers keeping some individuals and families across the state from receiving the health care and services they need.

Massachusetts community health workers possess a unique set of skills, identified here, that enables them to help communities in need overcome barriers to good health and health care. They can face difficult working conditions, poor compensation, lack of benefits, inadequate training and supervision, and few opportunities for promotion. The lack of a standard CHW definition and the lack of understanding among providers about CHW services contribute to the challenges they face.

Despite these challenges, Massachusetts CHWs combine their unique skill set with an extraordinarily high level of commitment to communities in need, and play a significant role in addressing some of the problems that exist in our present health system. By turning our attention

to the key workforce issues identified in this survey, we can increase the potential contribution CHWs can make in the future.

FUTURE ACTION STEPS AND AREAS FOR STUDY

The MDPH proposes the following action steps and areas for further study:

- Develop a set of core competencies and guidelines for CHWs.
- Offer CHWs training and supervision.
- Propose a career ladder for CHWs and their supervisors.
- Establish recommendations for fair and equitable pay scales for CHWs.
- Collaborate with the Massachusetts Community Health Worker Network.
- Conduct further research to document the unique contribution of CHWs to the health system, and educate health providers and policy makers about this contribution.
- Identify stable funding sources that promote long-term program planning and sustain CHW services.

CONCLUSION

Community health workers, key health professionals woven tightly into the fabric of the communities they serve, are a significant asset to the people of Massachusetts. Without their efforts, many residents would either go without health care and other vital services, or would access care when it is most costly. The impact of CHWs in Massachusetts is far reaching and has enhanced the efforts of many organizations and agencies within Massachusetts. All those in Massachusetts who wish to protect the public health must acknowledge the critical role CHWs play, and join together to support and sustain this key health care resource.

Introduction

Community health workers are an essential component of the health system. They provide the critical link between the health care and human service system and their communities. This report will answer the questions: Who are community health workers (CHWs)? What do they do? What are the defining issues of CHWs as a workforce? How can we better understand and support community health workers in order to improve public health outcomes in Massachusetts?

The Massachusetts Department of Public Health (MDPH) has as its mission to improve the health of all of the Commonwealth's residents. We strive to ensure that the people of Massachusetts receive quality health care, and we are especially dedicated to the health concerns of those most in need. Community health workers in Massachusetts are key to our success, and are critical to our population-based efforts to meet current challenges, such as access to care, the threat of bioterrorism, and racial and ethnic health disparities. Indeed, community health workers are uniquely qualified to reach our most isolated and vulnerable residents.

"Community health worker" is used today as an umbrella term to describe members of the health workforce that function under a multitude of various job titles. The MDPH has undertaken this investigation of CHWs in Massachusetts to be better able to develop effective strategies for their support, development, recruitment and retention.

Job titles that often fall under the "community health worker" umbrella

Abuse Counselor
Adult Case Manager
Case Coordinator
Community Coordinator
Community Liaison
Community Organizer
Community Outreach Worker
Community Health Educator
Community Health Representative
Community Outreach Manager
Community Social Worker
Counselor
Educator
Family Advocate
Family Education Coordinator
Family Support Worker
Health Advisor
Health Advocate
Health Agent
Health Assistant
Health Communicator
Health Educator
Health Insurance Counselor
HIV Peer Advocate
HIV Prevention Coordinator
Home Care Worker
Home Visitor
Home-Based Clinician
Intake Specialist
Interpreter
Maternal and Child Health Case Manager
Medical Representative
Mental Health Worker
Nutrition Educator
Outreach Advocate
Outreach Case Manager
Outreach Coordinator
Outreach Educator
Outreach Worker
Parent Liaison
Parent Aide
Patient Navigator
Peer Advocate
Peer Leader
Promotor(a)
Promotor(a) de Salud
Street Outreach Worker
Youth Development Specialist
Youth Worker

Background

HISTORY

Both in the United States and abroad, CHWs have been an essential component of health systems for many years. Historically, public health departments and health care agencies have used workers with these and similar titles to perform critical outreach functions. Outreach is a key strategy for improving access to and increasing utilization of primary health care, reducing costs of care, improving quality of care, and reducing health disparities. *Community health workers (CHWs) achieve these goals by serving as the bridge between clients in need and needed health care and human services.*

Since the 1960s, the federal government has supported the development of CHW programs as a way to improve health outcomes in underserved communities. Both the Federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964 mandated outreach efforts to neighborhoods with high poverty levels and in migrant labor camps. In 1968, the Indian Health Service (IHS) established the largest program in the U.S. to use the CHW model, which supports the use of CHRs (community health representatives) to work with tribal managers in most of the 550 federally recognized American Indian and Alaskan Native communities.

In 1965, Massachusetts established one of the first CHW programs under the Economic Opportunity Act of 1964, in the nation's first comprehensive neighborhood community health center at the Columbia Point Housing Project in Dorchester. For over forty years, the Massachusetts Department of Public Health has supported the use of effective outreach through its funding to community-based agencies, as well as in its own public health services.

The MDPH is the single largest funder of CHW programs in Massachusetts.

RECENT CHW INITIATIVES

In recent years, a number of nation-wide and state initiatives have been implemented in an effort to better understand the roles and impact of CHWs in improving health outcomes. Seminal among these was the National Community Health Advisor Study in 1998 (funded by the Annie E. Casey Foundation) that identified CHW core roles and competencies and also identified the need for strategic coordinated efforts to support the growth and development of the CHW field (Rosenthal et al., 1998).

The Pew Health Professions Commission noted that CHWs "fill an important access gap in the delivery system by demystifying system barriers and decrease the costs of care through their work in prevention and health promotion. As extenders of primary care teams, they can prevent unnecessary reliance on costly emergency department and specialty services" (Pew, 1994). By serving as liaisons between the health care system and the community, CHWs can improve the quality of care by educating providers about community needs and the culture of the community (Brownstein et al., 1992). CHWs make broader social contributions by organizing communities to identify and address their own health problems (Witmer et al., 1995).

In 2001, the Governing Council of the American Public Health Association issued a resolution with policy recommendations entitled "Recognition and Support of Community Health Workers' Contributions to Meeting our Nation's Health Care Needs" (See Appendix D.)

In its landmark report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" in 2002, the Institute of Medicine found that: "Community health workers offer promise as a community-based resource to increase racial and ethnic minorities' access to healthcare and to serve as a liaison between healthcare providers and the communities they serve." (Finding 5-2). The report goes on to make the following recommendation: "Support(s) the use of community health workers. Programs to support the use of community health workers (e.g., as health navigators), especially among medically underserved and racial and ethnic minority populations, should be expanded, evaluated, and replicated." (Recommendation 5-10). (See Appendix E.)

Recently, federal officials and several state governments have shown increased interest in the role of CHWs in reducing health disparities, improving access to care and making disease management more cost-effective. Training and other workforce initiatives are being implemented across the country. In the areas of credentialing and certification, Ohio has joined Texas in implementing credentialing for CHWs, and movements are underway in other states.

COMMUNITY HEALTH WORKERS IN MASSACHUSETTS

In Massachusetts, a number of efforts have been implemented on various levels to support and promote the thousands of community health workers employed in community-based agencies. Recognizing the need for improved training opportunities, the Boston Public Health Commission founded the Community Health Education Center in 1994, which developed and implements core CHW training. Other training models have developed over time, including the Outreach Worker Training Institute based in the Central Massachusetts Area Health Education Center in Worcester.

In an effort to better understand CHWs and their current and potential impact on the health care delivery system, the MDPH convened, in 1995, an internal cross-departmental CHW Task Force. The task force included representation from the broad range of programs utilizing outreach, such as HIV/AIDS, substance abuse, maternal and child health, nutrition, tuberculosis, chronic disease prevention and others.

One significant outcome of the CHW Task Force was the development of the "Request for Response (RFR) Guidelines for Community Health Workers" – a set of expectations for MDPH-funded community-based vendors about CHWs. It included:

- CHWs' roles and responsibilities (in essence, a broad "working definition")
- Development of an overall outreach plan
- Development of an internal agency plan for training, supervision and support of CHWs.

These guidelines were distributed with the 1997 "MDPH Community Health Network RFR," a $163 million per year grant program that supported many community-based agencies.

The MDPH CHW Task Force proceeded to convene several forums inviting input from Massachusetts community health workers, in order to determine next steps in promoting the CHW workforce.

The steps identified were:

1. **Survey the CHW workforce in Massachusetts.**
   Further study, with significant input from CHWs themselves, was needed to understand critical workforce issues such as job role and scope, training and supervision, level of integration into the health care delivery system, and barriers to recruitment and retention.

2. **Support the development of a statewide CHW network.**
   The best voice for promoting CHWs and the work they do is the voice of CHWs. A statewide CHW network, led by CHWs, would be capable of convening all key stakeholders in the state, and was needed to advocate for strengthening the field.

3. **Develop and implement a clear MDPH CHW Policy.**
   The current "RFR Guidelines for CHWs" needed to be further developed into an MDPH CHW Policy, to include a standardized CHW definition, best practices and operational measures for MDPH vendors using CHWs.

With funding support from the federal Health Resources and Services Administration (HRSA), the MDPH, in 2000, embarked upon the Massachusetts Community Health Worker Network Project – a broad-based three-year initiative designed to accomplish these three steps. (See Appendix A – CISS Grant Abstract). During the course of the project, all three were achieved. The second goal led to the establishment of the Massachusetts Community Health Worker Network (MACHW), a statewide CHW-led membership organization dedicated to advocating for CHWs and the communities in which they work (See Resource List – Appendix F.) The third goal (the MDPH CHW Policy Statement) was achieved through the combined efforts of the MDPH CHW Task Force, other MDPH programmatic staff, and the Massachusetts Community Health Worker Network (see Appendix C.)

The first step of the project, the assessment of the CHW workforce in Massachusetts, was the focus of the Massachusetts Community Health Worker Survey, and the findings are presented in this report.

Purpose of the Massachusetts Community Health Worker Survey

The primary goals of the Massachusetts Community Health Worker Survey were to:

- Determine basic socioeconomic and demographic characteristics of the CHW workforce
- Identify core job roles and functions
- Create a standardized definition of a CHW for MDPH contracts
- Identify unique skills CHWs require
- Identify job settings, wages and funding;
- Gather information on training and supervision
- Identify barriers to workforce recruitment and retention

The survey was administered to both CHWs and CHW supervisors. The survey research was funded by the grant from HRSA's Maternal and Child Health Bureau (MCHB) Community Integrated Service System/Community Organization Grants (CISS/COG) Program.

Survey Methodology

Because of the lack of data about CHWs in Massachusetts at the onset of this project, identifying a sample group for the MDPH survey presented a hurdle. Another significant challenge was the lack of a consistent, widely accepted CHW definition. Neither the MDPH nor any other organization in Massachusetts had ever compiled a statewide database of CHWs. The MDPH conducted a mass mailing to approximately 8,000 agencies and individuals. The mailing included a draft "working definition" of a CHW based on the current literature, and asked individuals whose role fell under this definition to contact the MDPH. The researcher interviewed these respondents over the phone to determine their eligibility to participate in the survey. Through this method the MDPH identified a total of 806 CHWs and 155 supervisors to take part in the survey.

To ensure CHW input in developing the survey questions, the MDPH utilized the newly formed Massachusetts Community Health Worker Network, as well as other CHW focus groups across the state. The surveys were mailed to the identified participants along with instructions, contact information, and a postage-paid return envelope. Participants were given three weeks to complete and return the surveys to the MDPH. After one week participants received a reminder notice by mail; after two weeks they received a phone call. Return rates were 371 (46%) for CHWs and 105 (67.7%) for supervisors. Analysis of frequencies was conducted using Microsoft Excel.

The MDPH used two surveys to collect information, one designed for CHWs and another targeting their supervisors, both developed in collaboration with community health workers and their agencies. Both surveys contained questions on demographics, work and work history, supervision, training and networking opportunities. In addition, the surveys contained questions specific to each role. In all, CHWs were asked to respond to 51 multiple-choice and open-ended questions; their supervisors responded to 38 questions. (See Sample Surveys in Appendix B.)

SURVEY LIMITATIONS

Several limitations arising from the survey sampling method must be taken into account when reviewing the findings in this report.

First, the fact that CHWs are an emerging profession, without consistent credentialing, certification or a defined job classification, precludes the possibility of determining the exact number of CHWs working in Massachusetts. Through this survey process we have identified at least 800 CHWs, and we estimate the actual number to be much higher for reasons mentioned in this document.

Second, a degree of selection bias is expected in self-reporting surveys. CHWs who were identified in the initial stages of the study may not have responded to the survey because of their own perceived role, literacy skills, time constraints, or other issues.

Third, a portion of the public health workforce that conducts outreach does not speak English as a first language. Time and financial constraints prevented translation of the surveys into languages other than English. Responses were, therefore, limited to English speakers, although many of these were bilingual or multilingual.

Fourth, the use of a draft working definition of a CHW based on current literature to identify survey participants may have included health professionals who do not fit under the resulting standardized definition.

Major Findings

With 474 individuals responding to the surveys (370 CHWs and 104 CHW supervisors), the findings are as follows.

DEMOGRAPHIC PROFILE

Gender
The CHW and CHW supervisory professions are predominantly female. Among CHWs, 76.2% are female; 23.8% male. CHW supervisors are 86.5% female and 14.5% male.

Race and Ethnicity
Of the respondents, 85% (n=405) self-identified their race as one or a combination of the following: White, Black, Asian, or "Other," which included American Indian, Alaska Native, Native Hawaiian, or Other Pacific Islander. Responses indicate that 80% are White, 12.5% are Black, 4% are Asian, and 3.5% self-identify as "Other." Six percent of the respondents checked more than one race. Fifteen percent (n=69) did not respond to this question.

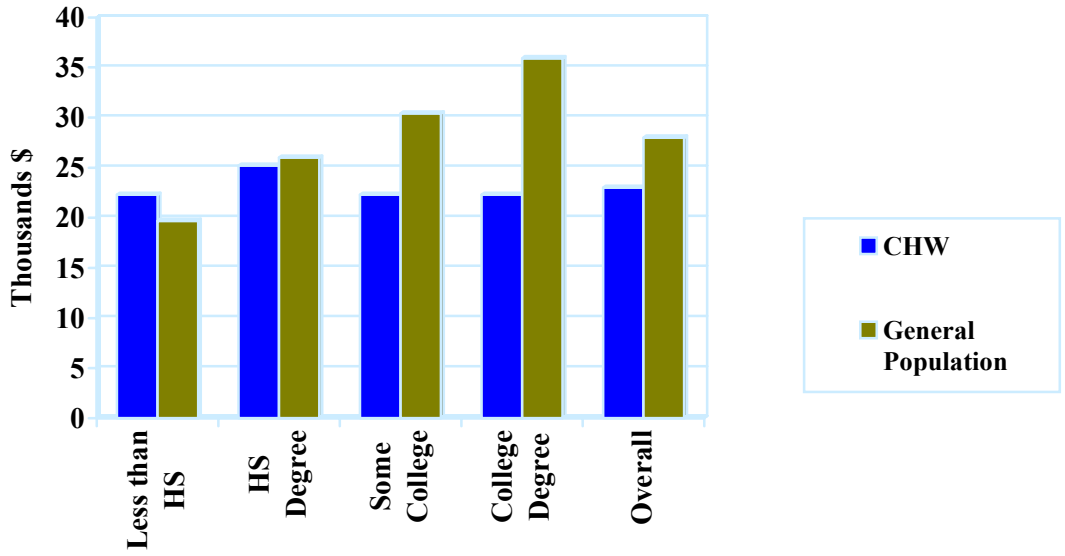
CHWs and their supervisors represent more than 20 ethnicities, reflective of the growing variety of ethnic populations in Massachusetts: Hispanic ethnicities represent 14.3%, including Central American (2.6%), Dominican (2.6%), Puerto Rican (8%), and South American (1.1%); Black ethnicities represent 8.9%, including African American (6.1%), African (.9%), Caribbean Islander/West Indian (.6%), and Haitian (1.3%); Asian ethnicities represent 3.3%, including Cambodian (1.3%), Chinese (.7%), Vietnamese (1.1%), and Laotian (.2%); Portuguese-speaking ethnicities represent 10.4%, including Portuguese (6.5%), Brazilian (1.7%), and Cape Verdean (2.2%); European ethnicities represent 7.4%, including East European/Russian (1.8%) and Other European (5.6%); 51% self-identify as American and 4.7% self-identify as "Other." Over 97% (n=463) responded to this question.

In addition, many CHWs speak two or more languages, including English, Spanish, Portuguese, Khmer (Cambodian), Vietnamese, Hmong, Lao, Chinese, Cape Verdean, Haitian Creole, and Russian.

Age
The median age range of respondents was between 36 and 40. Overall, CHWs and their supervisors ranged in age from 20 to 60. The median age range of CHWs was 36-40 years old. The median age range for their supervisors was 41-45.

Education
66% of respondents hold some form of community college, college or university degree. Of the CHWs, 60% reported holding some form of degree beyond high school. 19.2% had attended some college level courses beyond high school. 12.5% hold a high school degree or its equivalent, and only 4% do not hold a high school degree or equivalent. Among the supervisors, 87.5% hold some form of degree.

Figure 1
Average Yearly Income CHWs vs. General Population by Education



CHWs: Where They Work, What They Do, Whom They Serve

In addition to demographics, the survey findings reveal the following:

CHWs work in all areas of the state.
The largest concentrations of community health workers surveyed are found in urban areas (59.7%) such as Boston, Worcester, Springfield, Fall River, and New Bedford. However, CHWs are working in all regions from the Berkshires to Cape Cod and the Islands. 13.5% are working in rural areas.

CHWs deliver a wide variety of services in a number of different settings.
More than 50 distinct services or activities are provided by CHWs. These may include case identification and recruitment, health education, human service referrals, home visits, client case management that includes follow-up, counseling and other services. CHWs' job descriptions often do not reflect the multitude of tasks they perform.

Why such a broad role? Survey findings suggest that CHWs must keep current with a wide range of federal, state and local programs, eligibility criteria and application processes in order to pass on accurate information to their clients. Nearly all CHWs reported assisting clients with a variety of health issues. In addition, CHWs must be creative and responsive, often going beyond the scope of their core specialties. Their generalist skill set makes CHWs crucial assets for agencies providing services to clients with multiple needs.

CHWs work in community-based agencies (including community health centers and other human service organizations), local public health departments, state agencies, hospitals, health insurance companies, clinics, shelters and faith-based organizations.

CHWs provide services to diverse populations.
CHWs provide services and information to individuals and families representing more than 20 ethnicities.

In many cases, CHWs share characteristics with their clients.

- 77.6% of survey respondents share the same ethnicity as their clients.
- 45.7% share the same race.
- 72.8% of male CHWs reported targeting male populations.
- 67.4% of female CHWs focus their work with women.
- 28.9% of CHWs reported working with clients in their own age group.

CHWs possess a wide range of both life and academic skills.
CHWs bring to bear a rich combination of practical life skills and experiences, personal qualities, and knowledge about the community to address the health challenges they face. They also possess skills acquired through formal training such as counseling techniques, health education methods, first aid/CPR, language interpretation services, management skills and many others.

Survey results show that, when hiring CHWs, the skills most highly valued by supervisors are their communication and relationship-building skills. They are also hired for their knowledge of the city, region, neighborhoods and community they serve.

A Formal Definition Of A Community Health Worker

Based on the unique combination of skills and diverse roles identified by the survey, the MDPH developed the following standard CHW definition for use in public health practice, policy development and community-based contracts for services. The core roles identified by the National Community Health Advisor Study served as the foundation for the development of this definition.

The MDPH uses this definition to distinguish this outreach work force from other health care professionals working under MDPH contracts and in other settings.

MDPH Definition of a Community Health Worker (CHW)

A community health worker is a health professional who applies his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out at least one of the following roles:

- Bridging/culturally mediating among individuals, communities and health and human services, including actively building individual and community capacity
- Providing culturally appropriate health education and information
- Assuring that people get the services they need
- Providing direct services, including informal counseling and social support; and
- Advocating for individual and community needs.

A CHW is distinguished from other health professionals because he or she:
- is hired primarily for his or her understanding of the populations he or she serves, and
- conducts outreach at least 50% of the time in one or more of the categories above.

Workforce Issues and Barriers to Recruitment and Retention
Despite the growing need for community health workers in Massachusetts, there are numerous barriers to workforce recruitment and retention. Across the state, CHW job retention is low and turnover is high. A number of contributing factors emerge from survey findings.

There is no formal career ladder for community health workers.
More than 76% of CHWs reported that their only opportunities for advancement consisted of building skills and increasing levels of responsibility within their current position. Only 27.6% reported opportunities for promotions (change in role and/or increase in salary). These promotions are mostly to supervisory positions: 73.1% of CHW supervisors were former CHWs.

"I love the job, but there is no opportunity for advancement." – Community Health Worker

CHW wages are low.
The mean salary for CHWs is $23,000 per year. Salary levels for CHWs do not increase from this mean with educational level, experience, or years in the position. In fact, the average yearly income of CHWs in Massachusetts is roughly $6,000 less than the state average for the general population. CHWs with college degrees earn approximately $13,000 less than other individuals with college degrees in the general population.

In addition, many CHWs reported that they do not receive health insurance through their jobs.

"It's depressing to teach participants how to use the system and then go home and be unable to afford health insurance or pay my own bills because of my poor pay." – Community Health Worker

CHW job security is impacted by unpredictable funding.
Since funding for public programs in Massachusetts is appropriated on an annual basis, community-based agencies are uncertain of their program and operations budgets from year to

year. When asked about job security, 59% of CHWs reported a certain sense of job security. However, many respondents defined job security as the continual need for services in the community, rather than stable funding for their positions.

Of those who reported that they do not have job security, 77% indicated that that is due to changes in funding sources or unstable funding.

"I am in human services because of my interest in bringing services to persons with disabilities. Government funding, contracts and high turnover rate of staff are frustrating. Across the board, CHWs are not compensated fairly for their dedication." – Community Health Worker

CHW turnover is high.
CHWs average length of stay in a single job is from 3 to 4 years, and in the CHW field, from 4 to 5 years. Supervisors demonstrate slightly higher longevity with 4 to 5 years in a single position and 5 to 7 years in the field. The fact that a large percentage of supervisors were once CHWs suggests that promotions play a significant role in workforce retention.

"Until better pay and higher grade levels for experience and education are given to CHWs, this agency will continue to lose excellent people." – Community Health Worker

CHWs are eager to receive additional training.
Survey respondents almost universally reported receiving some form of training, on topics ranging from housing advocacy to injury prevention to HIV/AIDS education. 67.8% reported that they want more training.

58.5% reported that the training they receive is good. 18.7% called their training excellent. 66.1% reported having some input into the types of training they receive. Of those who receive training, 71.6% said that it is provided by their own agency versus an outside source.

"We need more training. We're working with people with such a wide variety of needs, it's impossible to be a specialist in all those areas." – Community Health Worker

Supervisors with CHW experience improve the quality of supervision.
79.1% of supervisors reported that they also function as CHWs or have been CHWs in the past. 75.1% of CHWs stated that their supervisors possessed CHW experience. 48.8% of CHWs said their relationship with their supervisors was excellent. 42.2% called the relationship good.

CHWs whose supervisors do not have direct CHW experience were twice as likely to report fair or poor relationships with them.

"Supervisors should be required to have worked on the front lines and be familiar with outreach." – Community Health Worker

SUMMARY OF FINDINGS

Poverty, limited English skills, lack of health insurance, unemployment, immigration and refugee status, homelessness, and an inability to access transportation are among the main barriers keeping some individuals and families across the state from receiving the health care and services they need.

Massachusetts community health workers possess a unique set of skills, identified here, that enables them to help communities in need overcome barriers to good health and health care. They can face difficult working conditions, poor compensation, lack of benefits, inadequate training and supervision, and few opportunities for promotion. The lack of a standard CHW definition and the lack of understanding among providers about CHW services contribute to the challenges they face.

Despite these challenges, Massachusetts CHWs combine their unique skill set with an extraordinarily high level of commitment to communities in need, and play a significant role in addressing some of the problems that exist in our present health system. By turning our attention to the key workforce issues identified in this survey, we can increase the potential contribution CHWs can make in the future.

Future Action Steps and Areas for Study

Progress made in the CHW field has gone largely unrecognized by the larger public health and health care communities. Given decreasing economic resources, the capacity of CHWs to continue to increase access, reduce health disparities and improve care is threatened at a time when there is an even greater need for their work. Recognition of the CHW profession along with institutional and systemic support are key to stabilizing this workforce.

With the survey findings in mind, the MDPH proposes the following 7 action steps and areas for further study:

1. Develop a set of core competencies and guidelines for CHWs.
To be most effective, CHWs must possess such competencies as communication skills, interpersonal skills, knowledge of the community, service coordination skills, capacity building skills, advocacy, teaching, and organizational skills. To further develop the profession, CHWs require a clear set of these core competencies, along with ethical and professional guidelines, to inform their activities as they work to assist those in need.

2. Offer CHWs training and supervision.
While most CHWs draw on their own life experience and communication skills to remain effective on the job, they also require formal training on an ongoing basis and consistent, supportive supervision to ensure that they can meet the community's changing health care needs in times of calm or crisis.

3. Propose a career ladder for CHWs and their supervisors.
As they gain the wide range of skills to perform this role, experienced CHWs, looking for advancement, often move to other professions. Implementation of a career ladder would

encourage seasoned CHWs to remain in the profession, adding to the quality of services delivered and providing greater opportunities for mentoring new CHWs.

4. Establish recommendations for fair and equitable pay scales for CHWs.
The low average salary of the CHW discourages both recruitment and retention. Appropriate pay scales for education and job experience would allow the profession to draw from a broader pool of candidates and encourage experienced workers to remain on the job.

5. Collaborate with the Massachusetts Community Health Worker Network.
The Massachusetts Community Health Worker Network (MACHW) was formed in 2000 to enable CHWs to lead the movement to organize, define and strengthen the profession of community health work. MACHW is a statewide professional CHW organization that provides leadership development, resource sharing, peer support, training and career development opportunities, and advocacy efforts to sustain CHWs and to promote secure and safe work environments.

6. Conduct further research to document the unique contribution of CHWs to the health system, and educate health providers and policy makers about this contribution.
For a deeper understanding of how CHWs enhance health systems, it will be important to conduct follow-up longitudinal studies to determine the costs and benefits of employing CHWs, examining their impact on the use of emergency services, preventive and primary care, and the management of chronic illness. Educating the broader health community about the role of CHWs will ensure that their potential is maximized.

7. Identify stable funding sources that promote long-term program planning and sustain CHW services.
CHWs have a significant potential to influence the ongoing health of communities by encouraging healthy behaviors across all stages of life. Because of their geographic coverage and community base, CHWs are also uniquely poised to deliver information and education in the event of a public health crisis such as a bioterrorism attack or a natural disaster. Stable, continuous and flexible funding will ensure that CHW efforts can be sustained, be responsive to community needs, and be maximized across an ever-changing health care environment.

Conclusion

Community health workers, key health care professionals woven tightly into the fabric of the communities they serve, are a significant asset to the people of Massachusetts. Without their efforts, many residents would either go without health care and other vital services, or would access care when it is most costly.

The impact of CHWs in Massachusetts is far reaching and has enhanced the efforts of many organizations and agencies within Massachusetts: community health centers and other community-based agencies, health access advocates, municipal and other local health departments, state agencies, CHW training programs, schools of public health and other academic institutions, foundations, hospitals, and health insurance organizations, and others.

CHWs champion the rights of all residents to access health care and other human services. They help people learn to navigate the system and to take responsibility for their own health and well-being. They enhance the effectiveness of preventive care in protecting individual and community health. All those in Massachusetts who wish to protect the public health must acknowledge the critical role CHWs play, and join together to support and sustain this key health care resource.

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Appendices

To view the Appendices, please go to: http://www.mass.gov/dph/fch/index.htm